HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

DISABILITY CERTIFICATION FOR DEPENDENT CHILDREN

PHYSICIAN'S STATEMENT

I certify I examined _____, birthdate _____ and found (him) (her) to be incapable of self-support because of a mental or physical incapacity which began on _____, before (he) (she) reached age 19.
(approximate date)

In my opinion, the above person:

☐ Will be incapable of self-support for the duration of (his) (her) life; or
☐ May become self-supporting if (he) (she) responds to treatment

Approximate date of recovery_____

Physician Name_____ Tel. No._____

Address_____
Street City State Zip Code

Signature_____ Date_____

PARENT'S STATEMENT

I certify that the above person is my child, is disabled, is dependent on me for support, and is not married.

I hereby request (he) (she) be continued as a family member under my EUTF benefit plans. I agree to submit additional proof of disability as often as required by the EUTF or its insurance carriers. I will notify EUTF of all changes affecting my child's disability or marital status.

I authorize the EUTF and its insurance carriers to use the above information only in compliance with federal and Hawaii laws governing the privacy of health information.

Employee/Retiree Name_____

Social Security Number (last 4 digits) _____XXX-XX-_____

_____ _____
Parent's Signature Date

Clear Form Print Form